Manchester City Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 25 June 2014 – 16 July 2014

Report published: 01 September 2014

The overall judgement is that children's services are inadequate.[2]		
The authority is not yet delivering good protection, help or care for children, young people and families. It is Ofsted's expectation that, as a minimum, all children and young people receive good help, care and protection.		
The judgements on areas of the service that contribute to overall effectiveness are:		
1. Children who need help and protection		**Inadequate**
2. Children looked after and achieving permanence		**Requires improvement**
	2.1 Adoption performance	**Inadequate**
	2.2 Experiences and progress of care leavers	**Requires improvement**
3. Leadership, management and governance		**Inadequate**

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

[2] A full description of what the inspection judgements mean can be found at the end of this report.

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The local authority

Summary of findings

Children's services in Manchester are inadequate because:

1. Inspectors found a large number of cases (486) that had waited a considerable time for a social work assessment, resulting in a significant number of children not having been seen or their needs assessed or recorded. This potentially left children at risk. The authority was aware of this issue but had taken insufficient action to address the problem.

2. Quality assurance and management oversight is not robust. It has been ineffective in dealing with serious drift in the completion of assessments.

3. Across all social work services, high social work caseloads mean that staff are often unable to prioritise and address children's needs effectively. This means that some children and families are not receiving good quality or timely services. Children and families have experienced too many changes of social worker, making it difficult to effect change. These weaknesses were identified at the last full inspection in 2010.

4. Poor understanding of thresholds by some of the statutory partners, together with poor engagement of agencies in early help, are contributing to high demand, which is not being effectively addressed.

5. Independent Reviewing Officers and conference chairs do not challenge poor social work practice effectively. Some conferences and reviews do not receive social work reports and the allocated worker does not attend. These meetings, and consequently the outcomes, are compromised as a result.

6. Too many children, particularly Black ethnic minority children, are waiting to be adopted in Manchester. Some children have not been adopted despite a plan for adoption. The pace of improvement in this service is too slow.

7. 35% of all children looked after do not attend good or better schools. This figure rises to 52% of secondary school children looked after in Manchester and means that their future outcomes are likely to be adversely affected.

8. The adoption panel and agency decision makers do not challenge poor work effectively and fail to ensure that necessary amendments to work are made, resulting in compromised decision making.

9. The local authority was unable to provide accurate data in relation to the number of care leavers in employment, education or training during the inspection. Data gathered did not support the local authority's view that there has been an improvement in performance in 2013–14.

10. Missing from care and child sexual exploitation processes are not well embedded, meaning that the local authority does not learn effectively from

these episodes.

What does the local authority need to improve?

Priority and immediate action

Workforce

11. Review the number of cases held by all staff, including newly qualified staff, to ensure that caseloads are manageable and that staff have sufficient time to plan and action their work. Ensure that there is a sufficient number of suitably experienced and qualified staff to deal effectively with current demand.

Quality of practice

12. Ensure robust management oversight on the single assessment process, at both first tier and senior management level, to ensure that children and families are seen and risks evaluated in a timescale that meets need. Ensure timeliness in completing assessments by reviewing at set points to ensure that children are seen promptly and that all work is recorded to an appropriate standard.

13. Ensure that the allocated social worker attends case conferences, looked after children reviews and other relevant meetings and provides a report that allows parents and carers and young people sufficient time to see, understand and comment on the report.

Children who are looked after

14. Ensure that case records are up to date and accurately reflect decisions made and the reasons for those decisions.

15. Ensure that return interviews for children who go missing from care are conducted by an independent person in accordance with statutory guidance.

16. Strengthen the quality assurance process for reports to the adoption panel and the role of the adoption panel in quality assurance.

Areas for improvement

Quality of practice

17. Promote the importance of stable relationships for children and young people with their social workers.

18. Ensure that the quality of assessment and report writing and an understanding of the importance of accurate and timely recording is understood across the workforce to ensure that decision making is based on all available information.

19. Prioritise the planning for young people needing transition planning to adult services, including children with complex needs, to ensure that it is carried out in a timescale that meets the needs of the young people and their carers.

20. Make clear the expectations for all looked after children in respect of attainment, particularly at secondary level, in order to close the gap between their performance and that of all children locally and nationally, ensuring that all looked after children have up-to-date and high quality personal education plans (PEPs).

21. Ensure a focus on giving care leavers sufficient opportunities to gain employment, education and training.

22. Ensure learning and change as a result of children's feedback and complaints.

The provision of help

23. The local authority and its partners need to ensure that early help is targeted and coordinated effectively, so that families receive support when need is first identified and the number of referrals to children's social care are reduced as a result.

24. The authority should seek to emulate its approach to and success with the troubled families programme through family intervention and the new children in need service, to ensure that help and support for families who struggle are timely and effective.

25. Review the capacity of the emergency duty service to ensure that it can offer a timely and appropriate response in line with demand.

26. Develop a shared protocol with the police for domestic violence notifications.

Services for looked after children and care leavers

27. Increase the participation of looked after children, including those placed outside the city, to ensure that their voices are heard and they are able to collectively influence decisions and policy.

28. Monitor the progress of over-16s through the Virtual Head Teacher to improve engagement with higher education and outcomes for care leavers.

29. Improve access to suitable accommodation for care leavers.

30. Improve the effectiveness of the independent reviewing officer service, particularly in relation to listening to the views of children, the rigour of challenge that is given to care plans and the process of escalation where there are continuing concerns about practice and progress of plans.

31. Prioritise and develop the recruitment of adopters to reduce further the mismatch of carers available to children waiting, particularly to meet the needs of Black ethnic minority children.

32. Develop foster to adopt and concurrent in-house provision and increase the use of voluntary adoption agencies.

Management and leadership

33. Undertake a quality assurance audit of supervision and ensure that there is sufficient management oversight on all cases, and that social work staff are receiving appropriate support, including time for reflection and help in achieving timescales and planning progression.

34. Improve the collation, accuracy and reporting of a range of performance information to ensure that the most up-to-date data are available across children's social care and are used to drive service improvements across all areas.

The local authority's strengths

35. The local authority has a strategic understanding of the need to develop and enhance with its partners early help services across Manchester in order to be able to help solve problems and prevent dependency at an early stage for children and families.

36. The local authority understands the need to ensure that its workforce is stable, and it has a workforce strategy that has delivered some improvements in staff turnover and reduced the use of agency staff.

37. The local authority has been successful in keeping most children in care in placements close to where they lived.

38. The local authority is successfully reducing the time it takes for children and young people to go through care proceedings.

39. Young people in care reaching the age of 18 are encouraged to 'stay put' with their foster parents, and many do so.

40. Children and young people in care enjoy access to recreational opportunities through the use of a free leisure pass, enabling them to develop skills and friendships in activities outside school.

41. There is a political consensus and commitment to budget protection for front-line social work services and additional funding to address the overspend resulting from the rising cost of placements for children.

42. The authority and senior management state their commitment to further improvements to reduce the volume of work entering social care and to closer front-line partnership work between agencies to ensure that families and children get the right services at the right time.

Progress since the last inspection

43. Services for children in Manchester were judged to be adequate in 2010. Since this time, there have been improvements in some areas, but overall, the standard of practice and management oversight has resulted in a reduction in the quality of social work services to children and young people.

44. There is a strategic commitment to helping families when concerns first arise. The troubled families service has worked with almost 3,000 families, and there is some evidence that parents and children value this help and that it is making a difference to their lives.

45. The authority has a good understanding of its effectiveness in some areas and, where such action has been taken, there is evidence of impact in addressing weaknesses. For example, a workforce strategy has been developed and progress has been made in significantly reducing reliance on agency staff. Cafcass has reported improvement in the assessments for court and notable improvement over the last year in the quality of evidence presented at court, which they now report to be good.

46. The local authority has refocused the balance of its in-house placement provision from residential to foster care. There are some recent examples of innovative approaches, such as use of the Social Impact Bond to develop the multi-dimensional foster care team to support young people with complex needs to move from residential care into foster placements.

47. There have been improvements to the quality of pathway plans and the quality of health assessments of looked after children and improvements in ensuring that the voice of the child is recorded. The local authority is encouraging young people to have a greater say in their reviews by introducing joint chairing. Some 120 young people have participated in this way over the last year.

48. Care proceedings timescales have reduced in the past 12 months and the proportion of children whose carers have a special guardianship order has increased from 7% to 11% in 2012–13.

49. There is strong political consensus and commitment to drive improvements in practice. Front-line social work posts have been protected from budget cuts and funding has been provided to meet the rising spend on placements for children in care and to develop services for children in care and on the edge of care.

50. The Corporate Parenting Panel has demonstrated some awareness of key issues; for example offering appropriate scrutiny, including a task and finish group to monitor the progress of each young person moving out of residential accommodation into foster care as a result of the integrated looked after children strategy. There are well established links between the Corporate Parenting Panel and Care to Change Council.

Summary for children and young people

- When children and families have problems, it sometimes takes too long to give them help. This means that some children and their families have to ask for help too many times. For some, this means that their problems have become worse before they get the help they need.
- Your social worker may change, and this means that you might have to keep telling your 'story', which can be difficult. Your social worker may have too much work to do, and this means that you and your family may not get the help you need quickly.
- If your family cannot look after you and you are being cared for by Manchester City Council, they will make plans for your future and will ask you for your views. For a lot of children and young people this means that the right decisions are made at the right time about where you will live and who you live with. The time it takes to make those decisions is getting shorter, but for some young people who need to be adopted, the time they wait for this to happen is still too long.
- Too many young people in care from Manchester do not go to a school that is good or better. It is important that you get the best education possible, and the council needs to make sure that you do as well as you can at school. At the moment, young people in care at secondary school do not do as well as they should.
- When you are leaving care at 18 it is important that you are able to be in education, training or employment. Manchester City Council tries to help you to do this, but too many young people are not getting this opportunity and the council needs to provide more help to ensure that young people are supported into work.

Information about this local authority area[3]

Children living in this area

- 108,152 children and young people under the age of 18 years live in Manchester – this is 21.5% of the total population in the area (source: data annex table 2.1.1).
- 36.6% of the local authority's children are living in poverty (source: data annex table 2.5.2.)
- The proportion of children entitled to free school meals:
  - in primary schools is 35.4% (the national average is 18.1%) (source: data annex table 2.8.1)
  - in secondary schools is 33.8% (the national average is 15.1%) (source: data annex table 2.8.2).
- Children and young people from minority ethnic groups account for 49.3% of all children living in the area compared with 21.5% in the country as a whole (source: data annex table 2.2.1).
- The largest minority ethnic groups of children and young people in the area are Asian or Asian British: 22%; and Black or Black British: 13.1% (source: data annex table 2.2.1).
- The proportion of children and young people with English as an additional language:
  - in primary schools is 37.8% (the national average is 18.1%) (source: data annex table 2.3.1)
  - in secondary schools is 31.2% (the national average is 13.6%) (source: data annex table).
- Additional contextual statement: Manchester's child population has been growing by around 2% annually over the last decade. The growth in Manchester's child population has, however, not been equally spread across the age groups: the 0 to 4 age band has risen substantially in number –almost 11,882 children or 46% between 2001 and 2013.

Child protection in this area

- Provisionally at 31 March 2014, 5,349 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 5,263 at 31 March 2013 (source: data annex table 5.3.51).
- At 31 March 2014, 920 children and young people were the subject of a child protection plan. This is an increase from 736 at 31 March 2013 (source: data annex table 5.3.47).

[3] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where this was available.

- At 31 March 2014, 29 children lived in a privately arranged fostering placement. This is an increase from 24 at 31 March 2013 (source: data annex table 5.3.61).

Children looked after in this area

- At 31 March 2014, 1,373 children are being looked after by the local authority (a rate of 122 per 10,000 children, which is an increase from 1,302 (119 per 10,000 children) at 31 March 2013 (in June 2014, this had risen to 1,406 children 128 per 10,000) (source: data annex tables 5.2.1 and 5.2.2).
- Of this number:
  - 751 (or 55%) live outside the local authority area
  - 120 live in residential children's homes, of whom 47% live out of the authority area
  - 11 live in residential special schools, all of whom live out of the authority area
  - 1,025 live with foster families, of whom 61% live out of the authority area
  - 115 live with parents, of whom 26% live out of the authority area
  - 12 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 63 adoptions
  - 24 children became the subject of special guardianship orders
  - 544 children have ceased to be looked after, of whom 6% subsequently returned to be looked after
  - 58 children and young people have ceased to be looked after and moved on to independent living
  - 32 children and young people have ceased to be looked after and are now living in houses of multiple occupation.

Other Ofsted inspections

- The local authority operates five children's homes. Three were judged to be good or outstanding and two as adequate in their most recent Ofsted inspection.
- The previous inspection of Manchester's safeguarding arrangements was in December 2010. The local authority was judged to be adequate.
- The previous inspection of Manchester's services for looked after children was in December 2010. The local authority was judged to be adequate.
- The previous inspection of Manchester's fostering service was in March 2013. The local authority was judged to be good.
- The previous inspection of Manchester's adoption service was in April 2011. The local authority was judged to be good.

Other information about this area

- The Director of Children's Services has been in post since April 2011 and is responsible for both children's social care provision and education services. The Director is also responsible for social work services for adults, but not for adult commissioning and placement provision.
- The Chair of the Local Safeguarding Children Board (LSCB), who had been in post since January 2009, left in June 2014. An interim appointment has been made.

Inspection judgements about the local authority

Key judgement	Judgement grade
The experiences and progress of children who need help and protection	Inadequate

Summary

The inspection found a large number of cases (486) where the assessment of need had not been undertaken within a reasonable timescale and a significant number of children and families who have not been seen, leaving them potentially at risk.

The local authority receives high rates of contact and referrals. Although the early help offer was agreed with partners in December 2013, not all partners are ready to work with lower risk but complex situations. This resulted in a large number of referrals continuing to be sent to social care for assessment. As a result, social workers have high caseloads and are not always able to complete and record their work or visit children within acceptable timescales.

The local authority has taken steps, including the introduction of a family intervention service, to reduce caseloads and ensure effective and early work to prevent children and families from requiring more significant intervention. This has not yet had an impact on reducing the number of children subject to protection plans or the numbers of children coming into care.

The quality of practice overall is too variable, and assessments and reports are not always of an acceptable quality and lack sufficient analysis. Management oversight of work and case progression is not robust.

Child sexual exploitation processes are not well embedded in social care teams, and the authority does not gather sufficient information to offer good analysis of activity in this area. Responses to children missing from home and care and private fostering are not sufficiently managed or evaluated to ensure that interventions are timely and effective.

51. The peer review in February 2013 highlighted that the use of the common assessment framework (CAF) was not fully embedded across the city. A wide range of training has been undertaken and there is now engagement by schools and health in the CAF process. There has been an increase in the number of CAFs undertaken (from 1,069 in the year to May 2013 to 1,417 as at May 2014). However, the pace of change has been too slow, so the authority cannot be sure that all children who need early help are receiving appropriate services. The quality of CAF assessments seen was too variable and expectations and outcomes were not always clear. Parents seen at a children's centre reported variable experiences of CAF, with one saying that they had been helped significantly and another that, apart from the centre, other agencies had not engaged. Children's wishes and feelings were recorded in most cases, but timescales were not clearly recorded, which means that families and professionals may not be clear as to when actions need to be completed.

52. There has been a renewed focus on early help, with a strategy agreed and launched in December 2013. Children's centres are now delivering a range of services, including services to promote school readiness. Some initiatives, such as the 'Stage Assessment model' for 0–5-year-olds, are resulting in some good outcomes, such as increased numbers of immunisations and improved attendance at health appointments. Currently, 75.2% of two-year-olds are accessing nursery provision, which demonstrates better performance than neighbouring local authorities. The local authority is on target to reach 80% by September 2014.

53. Not all partners have fully engaged in the use of CAF and not all professionals are fully informed about what early help services are available to families. An early help directory remains in the development stage. The partnership has not yet agreed a performance management framework to measure the effectiveness of early help. Without this, the local authority cannot know whether the early help they provide makes a difference in the long term. A small number of cases were seen during this inspection where children's needs should have been met at an earlier stage to prevent problems escalating.

54. Children who need help and support are provided with some effective interventions through the Troubled Families initiative. Since 2009, nearly 3,000 families have been supported through the programme. An evaluation in February 2014 of 294 families who had just completed the programme indicated that 73% of families who have accessed the service had stopped offending. There was some evidence of some good quality SMART (specific, measurable, attainable, realistic, timely) plans in family intervention project teams in cases sampled. Child protection enquiries are timely and conducted by suitably qualified workers. Strategy meetings are well attended by a range of agencies and are mostly face to face meetings, helping to ensure that information-sharing is timely and effective. Strategy meetings are not always clearly recorded and a small number seen had a scanned, hand-written entry that had not subsequently been corrected. Children are seen, and seen alone, and their wishes and views are recorded in the majority of cases seen.

55. There are a high number of contacts and referrals to children's social care, some of which are not appropriate. These result in contact officers and social workers in the First Response Team wasting valuable time processing unnecessary work. The lack of a shared protocol between the police and children's social care for the screening and management of domestic violence results in a very high volume of domestic violence notifications being passed to children's social care. A working group has been established to address this and a MASH (multi agency safeguarding hub) is planned for 2015, but current demand for services remains very high and the service is struggling to cope with the volume of work.

56. There is evidence that a wide range of 'agencies' know how to make a referral to children's social care and are doing so particularly where immediate safeguarding concerns are identified. However, not all partners fully understand or accept the thresholds of need that have been agreed. The LSCB has

identified that more needs to be done to provide confidence and skills to the early help workforce to manage more complex, but low risk, cases.

57. Immediate safeguarding concerns are passed to assessment teams for allocation. Remaining contacts are passed to the First Response Team, where effective information gathering and background checks are undertaken by qualified social workers to determine whether the contact should be progressed to a referral. Verbal consent is obtained from parents where possible to undertake background checks. However, where consent has not been obtained, checks are undertaken without consent. Decisions about contacts are not always made within 24 hours, which sometimes means a delay in children being seen by a social worker and assessments being started. In one case seen, this was five days.

58. Repeat referrals remain high at 32% and in a number of cases seen, opportunities to intervene earlier with children and families were missed, resulting in repeat referrals about children. None of these cases involved immediate risk of harm, but they indicated a 'volume of work' response rather than considered decision making from managers. This is adding to the capacity problems in the social work teams.

59. The inspection identified 486 single assessments that had not been progressed in a timely manner, including a small number that had drifted for almost a year (from August 2013). In many of these cases, although work had been undertaken, it had not been recorded or recorded well. Of these, 97 children had not been visited, including 44 for a period of six months, meaning that some children had been left in situations of unassessed risk. The local authority has now reviewed all of these cases to ensure that work has been undertaken and any outstanding actions have been progressed. The local authority review indicated that no child had been left at risk and no safeguarding action had to be taken as a result. Inspectors also undertook an audit of an additional sample of these cases and found that no child had been left at risk of significant harm. However, this backlog of unactioned and poorly recorded cases was widespread across all localities and indicated a systemic weakness in capacity and process that left some children at potential risk. The local authority and senior managers had been aware of this backlog and, although some action to reduce it had been taken, this intervention was insufficient to assess risk effectively, identify delay and to reduce known delay quickly.

60. Some social workers see the single assessment process as providing a prescription of 45 days to complete all assessments. A number of less complex cases would benefit from a briefer assessment period and could then be closed; other more complex cases may need longer to fully assess all aspects. Managers have recognised this and are planning further training to support social workers' understanding of the need for proportionate assessment.

61. Examples of assessments seen were of variable quality. Although the majority demonstrated focus on the child and management of risk, including examples of the voice of the child and analysis of cultural issues, others did not

demonstrate either sufficient analysis, including taking account of historical factors, or timely completion of work.

62. Caseloads are variable and for too many social workers they are too high. Some social workers had over 40 cases each and two workers had 50 cases. High caseloads mean that social workers do not have time to spend establishing meaningful relationships with all children on their caseload and are not able to effectively prioritise all their work.

63. Social workers in the court and locality teams take responsibility for children following an assessment to implement children in need, child protection and children in care planning. The quality of child protection and children in need plans seen overall was variable, although almost all seen had evidence recorded of the voice of the child and plans that addressed support issues. Some seen lacked a contingency plan. Assessments for court demonstrated analysis and an awareness of the needs of and timescales for the child.

64. Social workers provide reports in the form of assessments for initial child protection conferences and reviews. The quality of reports is variable, with some good examples of assessments of risk and inclusion of cultural factors. In a small number of cases, these reports have been brought to conference by a duty social worker. This has an impact on the quality of information and analysis that is shared and means that the family may not have met the worker before. Not all social workers routinely share reports with families in a separate visit but will share reports just before the review. This gives families too little time to take in information and ask questions.

65. The new child in need intervention service, currently being piloted in the north locality, has been developed to reduce demand on the statutory social work service by targeting children and families in need. The service had been operational for five weeks and was supporting 72 families at the time of the inspection. Families are being involved in time-limited work designed to improve their situation enough to be managed at a universal level. This service has been developed to complement existing work in the Family Recovery Service, which has brought together families first, systemic therapy, family intervention project and troubled families teams. The Family Recovery Service has worked with 339 children on the edge of care over the last two years. Eighty one per cent of these children did not enter care and this had been sustained 52 weeks later in August 2013. The systemic family therapy team has been commissioned since 2013 to work with a small number of children at risk of becoming looked after. It is too early to look at long-term outcomes, but of the 11 children who have completed the programme none has become looked after. Despite some promising work, the overall impact of these interventions has not been sufficient to prevent a rise in overall numbers of young people either entering care or being subject to child protection plans.

66. The core groups observed were well attended by professionals from partner agencies, who made positive contributions to the support and planning process. There was evidence of extensive support packages being in place for children and their families. Many of those attending, particularly the schools involved,

demonstrated that they knew children well and were able to both articulate the concerns they had and identify the impact on the children.

67. Most social workers seen receive regular supervision, although there were examples where supervision had not been on a regular basis. Recording of supervision does not evidence reflective practice. Training and development issues are recorded.

68. Out of hours services are covered by managers from children's social care working on a rota basis. They work effectively with the daytime teams and with the police. They have access to appropriate systems and support from senior managers on a 24-hour basis. With current arrangements providing one worker on duty for the city, the service can only respond to the most urgent situation at any one time. There are a high number of police protection orders – 191 in the last year – and, although the examples seen were appropriate, current limited capacity in the emergency response service is not likely to have an impact on reducing these.

69. Multi-agency risk assessment conferences are well established and well attended by partner agencies, which means that there is good information-sharing to help plan effective actions to reduce risk. There is a range of domestic abuse services available to children and their families, including a commissioned service for perpetrators and a therapeutic service provided by the Children's Society. Work with troubled families where domestic abuse is a factor has demonstrated that there has been a 64% reduction in incidents since families completed the intervention (2013–14). There is currently a review of services involving all stakeholders to ensure that services are available at the earliest stage of problems being identified. There is evidence of some creative approaches being used by the police to prevent domestic abuse, such as a project in schools to promote healthy family relationships.

70. In 2013–14, 30 young people at risk of being involved in gang-related issues were discussed at level 2 multi-agency public protection arrangements (MAPPA). In 60% of these cases, there was some form of safeguarding action taken. The multi-agency 'Protect' team, which includes police, social care and health, is providing effective services for young people at risk or potential risk of gang involvement and child sexual exploitation, together with training and awareness-raising across agencies. The co-location of the team with the Integrated Gang Management Unit and cross-borough work is leading to a well-coordinated response when risks are identified. The social care contribution is valued by agencies. There are robust assessments of need for children referred to the service and a range of bespoke interventions are currently provided for over 90 children and young people. Consultation and support is provided by the Protect team to agencies working with this vulnerable group. There has been some very effective work to target 'hot spots' and tackle offenders, and to provide a range of support to young people through street-based outreach work.

71. Allegations against professionals are managed effectively by the local authority designated officer (LADO) to reduce risk, and there is evidence that allegations

are dealt with in a timely manner. Of 54 referrals in the last quarter of 2013, 15 proceeded to a formal LADO strategy meeting and 27% of these have resulted in a criminal investigation, the remainder being offered advice.

72. Specialist disabled children workers have been integrated into the locality teams to improve the quality of safeguarding practice for disabled children. There has been dilution of the role of the specialist workers and in specialist knowledge, and a number of these workers have left the authority and are not being replaced. This means that some disabled children have social workers who are not trained to understand their particular needs and some transition arrangements for children into adult services are not being planned early enough, including some that are not initiated until after a young person has reached 17.

73. Some families spoken to said that it was difficult for them and their children to form stable trusting relationships with their social workers because of a legacy of a high number of changes in social workers. Where there was continuity of worker then inspectors saw some evidence of effective relationships being developed and of social workers doing direct work with children. The workforce has begun to stabilise in recent months and the number of agency staff have reduced, with 25 agency staff currently covering vacancies (out of 260 social work posts) and a further 17 covering maternity and sickness. Families seen said that they did have stable relationships with family intervention project workers and this had helped them to improve their circumstances.

74. The local authority has a clear policy on children missing from home, including the holding of strategy meetings. Evidence of adherence to this policy is variable. The Greater Manchester Police report positive multi-agency action on child sexual exploitation and children missing from care, with good use of strategy meetings to intervene and reduce behaviours. However, when children go missing from home, there is not always a coordinated response from the police and social care, and young people do not routinely have a return interview conducted by an independent person. Information on children missing from home does not show the length of time for which the young person was missing, whether a return interview was conducted, whether a strategy meeting was convened or where the child is currently missing from. This means that practice in this area is poorly monitored and there are insufficient links being made with children who may be sexually exploited.

75. At the time of the inspection there were 28 children who were assessed as being privately fostered. Over the past 12 months, the authority has not fully discharged its statutory responsibilities towards this group of children and visits and assessments have not been conducted within timescales. Only 52% were seen within seven days of referral, which means that children were not being seen and spoken to about their circumstances in a timely manner. Since May this year, the authority has taken a more proactive approach, with regular monthly audits, which has resulted in improvements to practice in this area.

76. All young people who present as homeless are referred to the 'City Centre project' for assessment unless they meet the threshold for child protection. Of

121 young people referred in the last quarter of 2013, 35 received a support plan that included accommodation and nine were considered as children in need. Very few are brought into care – only one in the last nine months. All of the cases sampled received an appropriate response.

Key judgement	**Judgement grade**
The experiences and progress of children looked after and achieving permanence	Requires improvement

Summary

The local authority is challenged by high and increasing numbers of children entering its care. This has meant that caseloads for its social workers are too high and the authority is struggling to maintain and improve standards of practice. The quality of the service that children receive is too variable.

The authority has not been able to ensure that there is sufficient placement choice, particularly for children with an adoption plan, some of whom wait too long to be adopted. However, the authority is succeeding in reducing the time taken for children to go through care proceedings and in keeping most children in care as close to where they lived as possible.

Care planning for children is variable and, although regularly reviewed, there is insufficient challenge from independent reviewing officers to address drift in plans and the lack of reports to reviews.

There are a range of services to help support foster carers with managing children's emotional and behavioural needs.

Some of the systems to ensure that work is of high quality are not as effective as they should be, for example the independent reviewing officer escalation process and adoption panel feedback.

While looked after children in primary schools have seen the attainment gap between them and their peers narrow, progress for secondary school children in care is not as good.

Pathway planning for young people leaving care is of good quality, but more needs to be done to ensure that young people leaving care have access to and take up employment, training and educational opportunities. Young people who wish to stay on with their foster carers at the age of 18 are encouraged to do so, but not all young people who leave care are in suitable accommodation.

77. The threshold for young people becoming looked after is robust, with decisions on entry to care being made by a senior manager, alongside a Family Resource Panel. This ensures that all children have a full assessment of need before becoming looked after or, in an emergency, soon afterwards. New entrants to care are also reviewed by the resource panel to consider whether alternatives may be more appropriate.

78. There are high social work caseloads. Social workers in looked after children teams have up to 30 cases while in court and locality teams dealing with a

range of work including care proceedings, workers have up to 40 each. There is a legacy of too many changes of social worker and a lack of robust management oversight resulting in permanency not being addressed with urgency in some cases.

79. The local authority's target of increasing foster placements by 100 in the period March 2013 to March 2014 has not been met, although placements have increased by 67, mostly through increased use of independent fostering agencies. The authority has been successful in reducing the number of placements of children in residential care, which is part of a long-term strategy that includes investment in specialist foster carers. However, there has been an increase of 101 children becoming looked after between June 2013 and 24 June 2014 that has placed additional pressure on placement choice. There is, in particular, a lack of availability for sibling groups, which has resulted in some brothers and sisters having separate placements. Where separations have occurred, there have been efforts to ensure that children are placed close by and in some cases with foster carers in the same family.

80. The Public Law Outline is being used effectively. In some cases, timely use of legal planning meetings has led to children's circumstances improving so that they can remain at home with their families. The average duration of care proceedings has reduced to 33 weeks and continues to show an improving trend, thus enabling permanence options to be achieved more quickly for some children. The rate of Special Guardianship Orders to carers has increased from 7% in 2011–12 to 11% in 2012–13. This has enabled more children to achieve permanence with carers they already know. There are positive relationships with Cafcass, who report an improved quality of assessments and plans from the local authority despite an increase in proceedings.

81. Nine per cent of children are placed more than 20 miles from home, which is less than the England and statistical neighbour figures (15.9% and 12.3%, respectively). This means that children can more readily maintain their local contacts and friendships. The authority has a strategic aim to reduce the use of residential accommodation and is undertaking planned closures of its own residential provision, with young people being moved to appropriate foster care placements in a planned way. Two thirds of residential accommodation providers (including in-house provision) have good or better judgements, with only one young person placed in inadequate residential provision at the point of inspection. The vast majority of independent fostering providers used have inspection outcomes of good or better.

82. High social work caseloads, changes of social worker and lack of robust management oversight have meant that in some cases, achieving permanence for looked after children has not been addressed with due urgency and this is one of the main reasons for independent reviewing officers escalating concerns to team managers. This issue has been recognised and a dedicated process to improve timescales in achieving permanence has been very recently established alongside a specialist independent reviewing officer for 0–5-year-olds, with the aim of ensuring that delays in the system are minimised. However, it is too early to assess the impact of these changes.

83. In some cases where there is a plan to return children home from care, there was insufficient evidence of work being undertaken to ensure that risks had been reduced and to address how children and young people's needs could be met by parents and carers. Management oversight in these instances was not sufficiently robust to ensure that work was completed and recorded to support successful rehabilitation.

84. Some looked after children spoken to did not feel that their social worker knew them well or that their complaints would be listened to. This is reflected in the findings from the complaints service, which identify the main reason for complaints as issues of poor communication by social work practitioners to young people, carers and other professionals. The children's rights service has been involved in active learning from complaints, and now supports an early resolution process by ensuring that social work managers speak to children and young people when a complaint is received to try and resolve them informally. This has been successful and has had the effect of reducing the number of complaints.

85. Manchester has 5.7% of looked after children known to misuse substances. This is higher than the England average of 3.5%. There is a dedicated service to support under-19s in reducing their substance misuse (Eclypse). During 2013–14, Eclypse received 31 new looked after children referrals. Data show that the vast majority of young people start intervention within three weeks of referral.

86. Unvalidated annual health data for looked after children for 2013–14 indicate that improvements have been made in ensuring that children looked after have up-to-date dental checks, from 90% in 2012–13 to 98.4% in 2013–14. There has been an increase in looked after children having up-to-date immunisations, from 90.1% in 2012–13 to 91.9% in 2013–14. The capacity of the looked after team within health services has been increased to improve compliance with statutory timescales and address the quality of health assessments.

87. There are a range of services to help support foster carers in managing children's emotional and behavioural needs, such as TOPS (Treatments Offering Placement Stability) for three- to six-year-olds and the 'KEEPS' (Keeping foster parents and carers supported) programme, which supports carers of children between five and 12. There is also a referral panel for Children and Adolescent Mental Health Services (CAMHS), which offers consultation to social workers and foster carers to help them care for children with emotional and behavioural needs. These services are part of the overall CAMHS looked after children service, which also includes provision of therapeutic intervention through integrated CAMHS provision in looked after teams.

88. Very slight improvements have been seen in long-term stability – 63.7% in 2013–14 from 63% in 2012–13. Short-term placement stability (fewer than three placements in a year) has improved substantially to 8% in 2013–14 and now compares favourably with statistical neighbours at 10% and England 11% rates for 2012–13.

89. Although independent reviewing officer caseloads are high, with an average of 110, looked after children reviews are held on time. Care plans for looked after children mostly reflect their current arrangements and are regularly reviewed at looked after children reviews to ensure that they meet the child's changing needs. However, in most examples seen, these were brief documents and it was not clear how the young person and people caring for them had been involved in their development. Health, education, contact and well-being needs were not always clearly set out. Levels of contact with families were frequently commented on by children and this is reflected in case records, but not always in care plans. There were some good examples in casework of children being helped to understand the reasons for contact being set at specific levels.

90. The quality of case records overall is not of a high standard, with social work visits not always on the electronic file system (MiCare), reports to looked after children reviews not provided in many cases, reviewing officers' reports from looked after children reviews not being uploaded for some weeks or months and documents not uploaded with the correct dates. This makes it difficult to understand why decisions have been made, who made the decisions and how children can be helped to understand them. Independent reviewing officers are not always able to meet with children between reviews and their quality assurance processes are not used effectively to drive up collective performance.

91. Some individual case sampling identified a small number of cases of children who are going missing from care and are at risk of child sexual exploitation that have been effectively safeguarded. However, overall, this is not consistent, with the majority of cases sampled identifying that the reasons for young people going missing and the continued risks from child sexual exploitation are not fully understood or explored, potentially leaving children at continued risk. New processes to improve collation of data so that trends and patterns can be collected are not yet in place, although the LSCB has recognised this and commissioned a multi-agency suite of performance information to be in place in August 2014.

92. Looked after children spoken to all said that they felt safe at home and at school. A youth offending service inspection in July 2013 noted a significantly improved working relationship with social workers where children were looked after. Evidence in case files supported this. Offending rates of looked after children have been higher than England and statistical neighbours for the last three years, but over this time there has been a reducing trend: 7.1% of children offended in 2013–14, a decrease from 8.1% in 2012–13.

93. Over the last three years, there has been a rise in the standards reached by looked after children in primary school. Last year, they performed better than looked after children across the country but less well than all children locally and nationally. In 2013, the proportion of 16-year-old looked after children gaining five GCSEs grades A*–C (including mathematics and English) declined. This figure was in line with the national average, but well below the results for all Manchester pupils and for all pupils across the country. The gap between the performance of looked after children and that of all children has narrowed at primary level. At secondary level it has fluctuated, and in 2013 was wider than

in 2009. Eighty per cent of primary school children attend a good or better school, but this falls to 48% at secondary level.

94. A fifth of looked after children do not have an up-to-date personal education plan (PEP). Most of those without a PEP are placed out of authority. The quality of the random selection of PEPs seen required improvement. The local authority does not monitor whether all looked after children have at least 25 hours of education each week. These are omissions in ensuring successful outcomes for looked after children. There are systems in place to track children missing from education and a demonstrable reduction in fixed and permanent exclusions. There are currently 172 children educated at home. Suitability of provision is appropriately monitored and acted on. Parents are informed of options available and offered advice and guidance. There are processes in place for managed moves of children between schools and a service level agreement between the local authority and pupil referral units (PRUs) to provide education for those children excluded. The quality of alternative provision is monitored by the PRUs, with other providers visited twice a year.

95. Children and young people spoken to enjoyed access to recreational opportunities through the use of a free leisure pass. This increases their resilience. Foster carers were supportive of extra-curricular activities, but not all were aware that they could have access to the pupil premium funding for activities such as music lessons, as this funding is currently channelled through schools. From September 2014, the funding will be allocated through the virtual head teacher, and all foster carers will be advised how they can access it and how it can be used. Some foster carers spoken to stated that they did not have delegated authority for children they cared for. Most young people spoken to were aware of their entitlements.

96. There is a Children in Care Council (Care to Change), which has a younger component as well as young people who are care leavers. The group has undertaken a variety of activities and consults with a wider group of looked after young people and care leavers, but the authority was unable to provide an overall figure of those involved. Some recent activities have included delivering Total Respect training and Voice of the Child training to independent reviewing officers, helping them to consider how their meetings can be more child-focused. There has been a recent successful pilot for older children being supported to co-chair their reviews, with 120 young people doing so over the last year.

97. Independent reviewing officers commented positively on the way that some schools and foster carers supported children with communication needs to contribute to their reviews, and that foster carers are good advocates for children in meetings. Other methods of supporting young people's participation in looked after children reviews, through attendance, formal advocacy and leaflets such as 'have your say', are used, but these are not collated and used to inform practice.

98. Foster carers gave some good examples of how they had effectively supported children from Black or ethnic minority backgrounds to respond appropriately to

racism from other children at school, and had promoted positive self-image. This illustrated how children are supported by carers when bullied or face discrimination. There is both a telephone and a face-to-face translation service available for children whose first language is not English are placed with carers who do not speak their language (usually as an emergency short term measure).

The graded judgement for adoption performance is that it is inadequate

99. The time taken from a child being received into care in Manchester to being placed for adoption in current published data is higher than statistical neighbours, at 740 days. This means that children in Manchester wait 203 days longer than the government threshold to be adopted (local authority 2013–14 data) and 56 days more than statistical neighbours (2012–13 data). More recent unpublished and unvalidated data collated by the authority indicates there have been some recent improvements. This performance is improving as a result of swifter processing of care proceedings following the implementation of the Family Justice Review reforms.

100. The local authority has implemented a number of recent changes to raise performance in achieving permanence. These include a very recent additional resource to the independent reviewing officer service to track cases involving children aged 0–5 years. In addition, Permanency Planning meetings are held before the second LAC review, and a Connected Carers Team is in place that focuses on speeding up assessments of family and friends. This is having an impact on the speed with which care proceedings are completed, but these measures are relatively recent and this means that overall performance remains poor.

101. This year, there has been an increase of 12 more children adopted than the previous year. Now, 11% of the looked after population achieve permanency through adoption in Manchester (67 in 2013–14). This figure is commensurate with national averages but lower than statistical neighbours.

102. A low number of Black minority ethnic children are placed for adoption in comparison with statistical neighbours (7% 2013–14, 9% in statistical neighbours 2010–13). Renewed focus on this group has found some new adopters, and this has helped improve performance, with a rise, from 16 children successfully placed in 2013 to 23 in 2014. The 2013–14 Annual Adoption Report says: 'These children (BME) wait much longer to be matched, even if they are under the age of 2 years.' The 2012–13 adoption data set indicated that, while there where 47 Black minority ethnic children waiting to be adopted, there were only nine Black minority ethnic adopters available.

103. The time it takes to match children with adoptive families in Manchester is 225 days. This means that children in Manchester wait 73 days longer than the government threshold and 16 days longer than statistical neighbours (based on last year's performance). The length of time that children wait to be adopted

has an impact on how well they settle into their adoptive placement. In a small number of cases, inspectors found that children had waited for three, five, seven and nine years to be placed, indicating that management of these cases had not been robust and these children had waited far too long for an achievable permanency plan.

104. The use of concurrent placements and foster to adopt placements, which could reduce the time spent waiting to be placed, is at a very early stage of development and implementation and is not yet making an impact. The local authority has approved one foster to adopt placement very recently and signed an agreement with Caritas, an independent provider, to provide concurrent placements while in-house provision is built up. Because these steps are very recent, children in Manchester have not yet been able to benefit from this service.

105. Incorrect analysis of data provided to the Department for Education by the local authority for a number of years has obscured the real performance around matching and the number of decisions to change plans away from adoption. This has reduced the authority's capacity to understand its true performance and has meant that the authority has not recognised deficits in adoption performance quickly enough to implement improvements.

106. Better arrangements for tracking and reviewing the children waiting for an adoptive placement have been put in place since the end of 2013, and a number of plans for children who have been waiting some time have been changed from adoption. However, the vast majority of these (56 out of 63) have moved to long-term fostering, which is potentially a less secure and less stable long-term outcome for these children.

107. The percentage of children for whom the permanency plan has changed from the original plan of adoption is 16%. This is considerably higher than statistical neighbours and indicates that some children have waited too long for a permanent solution.

108. There are 106 children waiting for adoption and 59 approved adopters in Manchester. This means that it is difficult to find suitable placements for the children waiting for families and this causes delay.

109. Manchester has had a campaign to find additional adopters and recently increased the use of voluntary adoption agencies. Manchester has attended six events around the country and it uses a range of places to advertise children needing a family, including the Adoption Register and its local consortium, Adoption 22. This has succeeded in finding and approving 12 more adopters than last year, but more needs to be done to make up the shortfall.

110. Inspectors spoke to three adopters about their experience of the recruitment process. Although the adopters spoke highly of the support and training that they had received from the service, two had experienced a delay of a year in being assessed and one had had a delay of several months.

111. The Adoption Panel is properly constituted, with a medical and legal advisor, independent members and an adoption advisor. It is chaired by an experienced independent chair and provides a six-monthly report to the Scrutiny Committee about performance. It meets weekly to consider cases, which is sufficient to process the work load. The minutes are of good quality and are produced promptly within timescale.

112. The last Manchester adoption panel quality assurance report stated that approximately half of children's permanency reports to panel were of poor quality. They lacked sufficient analysis about the child or the match, were inaccurate, were not up to date, did not record parent's views accurately and/or read like a court statement. In one example of a poor case report seen by an inspector, the report contained inappropriate commentary about the child's mother. The quality of the reports causes delay to the process because the panel rejects some of them. In addition to delaying the progress of the case, this causes inconvenience and distress to adopters. Poor quality reports also mean that the child's record for later life contains potentially important inaccuracies or flaws in the official record of their history and family.

113. The Adoption Panel's attempts to address the quality of the child's permanency reports have not been effective, and some reports have not been amended after being criticised by the Panel and the agency decision maker.

114. Manchester has a good range of post-adoption support available, which has been accessed by over 200 adoptive families last year. In addition to the statutory Adoption Support Services Advisor, there is a service level agreement with the Manchester After Adoption Service to provide a range of support, including two family days for adoptive families, counselling and groups for adopted children. There is also support from the Post Adoption Psychology Service provided through CAMHS; a 16-week accredited parenting course and a new pilot called Wrap around Adoption, which currently provides an intensive support package to one family. Adopters spoke highly of the support that they receive.

115. Disruptions are low, which suggests that, despite the poor quality of the reports, matching and post-adoption support is effective.

116. Life story work takes place for children placed for adoption and is of good quality, helping children to understand the reasons for their adoption in a child-focused way. It was valued by the adopters spoken to.

The graded judgement about the experiences and progress of care leavers is that it requires improvement

117. The Leaving Care Service in Manchester is commissioned by the local authority and delivered through 'The Curve', run by Barnardo's (since 1995), who provide the pathway planning and a personal advisor to young people leaving care. The work of The Curve is evaluated and overseen by the Multi-agency Leaving Care Group, who report to the looked after children Improvement Group.

118. There are a range of support services available to care leavers to assist them in the transition to independence. The service runs a drop-in centre once a week that provides one-to-one support to access accommodation, apply for jobs or access training, complete CVs and apply for benefits or privately rented housing.

119. The pathway planning seen by inspectors was detailed and thorough. Appropriately qualified and supported personal advisors assess the needs of young people moving into independence and develop plans with them that put them in touch with services that can help them. The pathway plans seen gave a clear indication of the educational achievements and aspirations of the young people concerned.

120. In most cases seen, the health needs of young people were comprehensively reviewed, including their emotional well-being and sexual health. Support was offered through a range of services, including CAMHS, the My Time counselling service, the befriending service, sexual health clinics, psychological support and other community resources. The looked after children nurse provides care leavers with advice and support around their health and the young people were registered with GPs. In all cases seen, young people received effective, timely support from their personal advisor to make the transition to independence.

121. Young people spoken to valued the support that they had received from The Curve highly and thought that their Pathway Plans were helpful tools to assist them towards achieving independence.

122. In five cases seen, where there were issues around risk, there were detailed and comprehensive risk assessments on file that were reviewed regularly. Appropriate steps were put in place to reduce the risk of harm to young people. However, in one case, while the direct work with the young person had reduced risk, concerns had not been escalated appropriately to children's social care. This meant that the effectiveness of the work to address harm to this particular young person was reduced.

123. The Leaving Care Service is in touch with 94.6% of its young people, which is in line with statistical neighbours. In cases seen, personal advisors demonstrated engagement with vulnerable or hard to reach young people, and this was helping to achieve some positive outcomes. Young people reported being well supported by their personal advisors, who knew them well.

124. There is a Care Leavers' and Director's Pledge that is given to all care leavers when they join the service in an information pack. Although this sets out care leavers' entitlements, including the financial policy and the complaints procedure, the material given to care leavers needs to be updated. There is no health passport in Manchester, so care leavers do not leave care with all their health history available to them.

125. Although young people knew how to make a complaint, three out of four young people spoken to said that services were not responsive to complaints when they were made (e.g. Housing, Children's Social Care). One young person had

made a complaint which they felt had been responded to well, while another young person said that they had been the victim of racial harassment where they lived for a number of years and had complained about this, but no action had been taken.

126. The local authority gives priority to care leavers in the city-wide partnership strategy to address youth unemployment and skills across the city. The city has an apprenticeship scheme that has benefited 14 care leavers, 12 of whom are still engaged in level 2 or 3 apprenticeships. Barnardo's also provide short work experience for 12 young people through an apprenticeship scheme in the hospitality industry. This has led to some employment opportunities for seven care leavers.

127. Of the full cohort of young people leaving care over the last three years, 9.8% are in years one to three of a university course, which is higher than the national average. In 2013, the proportion of 19-year-old looked after students entering higher education overall was 7%, with 12% of all care leavers in higher education.

128. The Virtual Head does not monitor the educational progress of young people over the age of 16 or during their time at university. This limits the local authority's capacity to track and promote achievement.

129. In 2012–13, the number of care leavers who were in education, employment or training was 59%. During the inspection, the percentage of care leaves who are in education, employment or training was not consistently and accurately recorded or reported by the local authority. This made it difficult for inspectors to gather a true picture of the numbers care leavers in education, employment or training at the age of 19. Senior managers reported that there had been an improvement in the number in education, employment or training in the last 12 months. However, conflicting data presented at the time of the inspection did not support this.

130. Young people in Manchester have access to a range of accommodation, from supported lodgings to a variety of supported hostels, supported living and rented accommodation. Care leavers are encouraged to make use of the 'Staying Put' offer, and over 64% of the young people in foster care turning 18 in 2013–14 stayed with their carers. There were no care leavers in bed and breakfast at the time of the inspection and the local authority has agreement from councillors that no care leavers will be considered 'intentionally homeless'. The local authority is seeking to further develop provision in this area. The authority does not run a care leavers' survey to inform itself about care leavers' experience of their accommodation.

131. Despite a range of accommodation on offer, only 81% of young care leavers were in suitable accommodation in 2013, below statistical neighbours at 91%. Data from the local authority for 2014 indicate that 83% of care leavers up to the age of 21 are living in suitable accommodation. Thirty young people are recorded as living with friends and 32 are in multiple occupancy, indicating that,

for some young people, Manchester is not yet meeting their accommodation needs.

132. The local authority has a transitions protocol for young people who need an adult service at the age of 18. A transitions panel is held to review and plan for post-18 care, and a joint assessment is carried out of the care leavers' needs by both adults' and children's social workers. The timeliness of this work is variable, with these referrals usually being made after the young person had turned 17. This means that young people may not know what their plans are until they are nearly 18, which is unsettling and does not give vulnerable young people security about their future.

Key judgement	Judgement grade
Leadership, management and governance	Inadequate

Summary

The senior leadership of the local authority was unaware of some of the weaknesses in services to children and families identified through this inspection. Management oversight, performance management and quality assurance processes are not robust.

Despite a commitment to driving improvements, the authority has been slow in many areas to respond in a timely and effective manner both to reviews of service and to changing demographic demands. Some of the recommendations from the previous inspection (December 2010) have not yet been actioned.

The local authority and its partners have not yet succeeded in ensuring that early help is making a difference in reducing demand, despite good examples of innovative work. High caseloads for social workers mean that they are not able to deliver good enough services in a consistent manner. Some families and children have not had their needs assessed and have been left at potential risk.

While some work has been undertaken to strengthen management oversight, more work needs to be done through performance management to ensure that it is consistently robust and effective across all areas of the service, and that it clearly identifies weakness and takes prompt action.

Partnership working is well established, but there remain real challenges across the partnership, including the local safeguarding board, for example a coherent application of thresholds and engagement of all partners in the delivery of early help.

There is a political consensus and commitment to budget protection for front-line social work services and to additional funding to meet the rising costs of placements for children. The local authority understands its corporate parenting responsibilities and the need to listen to and hear children in care and their experiences, but it needs to be more challenging about the quality of services to children and young people.

133. The Strategic Director Children and Families and his senior management team are committed to driving improvement in the quality of services to children young people and their families, and have made efforts to respond to the peer review and independent safeguarding review in 2013. However, progress in some areas has been too slow to meet changing demands and high levels of need within the city, and many of the initiatives are either too new to show impact or are only just beginning to have an impact.

134. A slow response to address some areas of weakness means that services for children do not always provide a timely and consistent response. Some children have not had their needs assessed and many have waited too long to be seen,

leaving some at potential risk. The quality of service provision is too variable. A legacy of poor practice in a small number of teams has resulted in some children having to wait too long for an adoptive placement. Over 50 children thought suitable for adoption have had their plans changed to long-term fostering. Senior managers have recognised this and have recently recruited new managers in the fostering and adoption teams, undertaken targeted work to address historic drift and delay, and sought to increase the recruitment of foster carers and adoptive parents. However, action to address deficits has been too slow.

135. Changes in demographics, including a rapidly increasing child population and high levels of deprivation and domestic abuse, mean that many families in Manchester have complex needs. There has been a significant increase in the numbers of contacts and referrals in 2013–14 and an increase in the number of looked after children. Many agencies, including children's social care, are struggling to manage the current level of demand, and this is putting pressure on many aspects of the service.

136. Many of the plans to address high and increasing levels of demand are long-term initiatives that are yet to fully evidence impact. For example, while a range of services are available to families through the 'Family recovery initiative', many of which are showing impact, the 'early help offer' is not yet fully coordinated and targeted, so not all children and families in need of help at an early stage of problems arising have access to the support they need. There is some evidence of early help providers offering good, targeted help to children with disabilities that reduced the need for referral to statutory children's services. However, overall, there is no evidence of impact of early help in reducing the number of referrals to children social care. The local authority recognises the need for its partners to be fully committed to engagement in provision of early help if this is to be effective in reducing the demands on child protection services, but progress on this has been slow. This is one of the most significant challenges that the partnership needs to address.

137. Too many social workers, including newly qualified staff, have high caseloads. This is affecting the ability of workers to complete assessments in a timely manner and, in some cases, reduces opportunities for social workers to undertake direct work with children. The authority has taken some steps to address caseloads; for example, there has been significant investment in the north locality to reduce social work caseloads through the establishment of the new child in need team, which is currently working with 90 child in need cases with a target of 420 over the next 12 months. This work is very recent and is only beginning to have an impact.

138. The authority has recognised the need to strengthen management oversight of practice and has effectively tackled some poor performance, including the capability of a small number of managers. A number of new team managers have been recruited, and training and mentoring is in place to support their professional development. A range of systems for tracking and monitoring children and young people in need of help and protection and those who are looked after has been introduced. This includes the recent establishment of a

dedicated team to track all 0–5-year-olds coming into the system. Examples were seen during this inspection of where this is improving practice in ensuring that timely decisions are made about how to respond to children's needs. The Principal Social Worker is playing a key role in driving up practice standards through increasing professional development opportunities and training for team managers.

139. As yet, it is too early to see the impact of all of these measures. Management oversight is not yet sufficiently robust and effective across all areas of the service. Supervision is mostly task-centred, with little evidence of reflective supervision. Newly qualified social workers receive regular reflective supervision from social work consultants, but this is not routinely available to all staff.

140. The local authority has a good understanding of its effectiveness in some areas, and there is evidence of impact as a result of actions taken to address weaknesses in a number of areas. For example, the need to ensure the stability of the workforce is underpinned by a workforce strategy and considerable progress has been made in significantly reducing reliance on agency staff by recruiting over 50 social workers into permanent posts since the autumn of 2013. This is beginning to result in more stability within some social work teams, but it is too early to see evidence of impact for children and families. In addition, Cafcass reports a significant improvement in the quality of evidence presented at court over the last nine months, which they now report to be good, including improvements in assessments, chronologies and care plans. This is resulting in more timely decision making for some children to ensure that their need for stability is met.

141. The development of the performance information framework and a wide range of audit activity are leading to improvement in the authority's understanding of performance, with some evidence of impact, but performance management is not yet sufficiently comprehensive and robust. There is routine reporting of performance information to the Children's Board, the Manchester Safeguarding Children Board (MSCB) and the multi-agency improvement board. The Performance Improvement Board, chaired by the Director of Children's Services (DCS) and attended by the Assistant Chief Executives (People) and (Business and Finance), receives a range of performance reports and audits and provides evidence of robust challenge from the DCS and Assistant Chief Executives to performance and quality of practice. Performance in some areas has improved as a result of oversight, for example improved tracking of children who are voluntarily accommodated under section 20 of the Children Act 1989. There is some evidence that audit activity is driving improvement; for example, the quality of information being sent as a referral from the First Response Team to the assessment teams has improved and was seen in many cases sampled by inspectors in the assessment teams.

142. Evidence of sustained change as a result of performance management and monitoring is limited, as many of the arrangements to support this are relatively new. The Children's Board does not receive performance data across all areas, and this means that they cannot be assured of robust oversight of all areas of practice. Some of the audits of individual cases undertaken by the local

authority for this inspection were not sufficiently robust or focused on the quality of practice.

143. There is wide representation on the Children's Board and the priorities of the Board are closely aligned with the Health and Well-being Board. There are clear lines of accountability and responsibility between senior officers, the lead member and the chair of the MSCB. There is some evidence of partnership working at a strategic level, with a range of initiatives, including the proposed development of the Multi Agency Safeguarding Hub (MASH) and the eight stages of assessment model delivered by health visitors and outreach workers to 0–5-year-olds in some areas of the city. Despite this, there remain real challenges across the partnership, including the MSCB, for example in addressing the high number of children subject to police powers of protection and in a coherent application of thresholds together with full engagement of all partners in the delivery of early help.

144. There is strong political consensus and commitment to drive improvements in practice. Social work posts have been protected from budget cuts and funding has been provided to meet the rising spend on placements for increased numbers of children in care. The authority is meeting increasing demand by 'managing demand differently', through analysis of the cohorts of children and young people in need of help and protection and care and investing in evidence-based interventions to meet identified needs, including recruitment of a wider range of foster parents. Learning from the Troubled Families initiative, which has shown positive outcomes, has been used to develop a range of services to meet demand through effective commissioning and in-house provision. There are some recent examples of innovative approaches, such as use of the Social Impact Bond to develop the multi-dimensional foster care team to support young people with complex needs to move from residential care into foster placements.

145. The Chief Executive takes an active interest in the progress and outcomes for children and young people in the city, and meets regularly with the Director of Children's Services and Lead Member and Chair of the MSCB to jointly consider a range of reports and ensure that he understands the service. However, the rigour of challenge over some aspects of service delivery, including the quality of social work practice with looked after children, has not been effective in driving improvement.

146. The Corporate Parenting Panel, including the Lead Member, is well informed about most key issues, and there are examples of corporate parents fulfilling their responsibilities well. For example, a task and finish group was established by the Corporate Parenting Panel to monitor the progress of each young person moving out of residential accommodation into foster care as a result of the integrated looked after children strategy. There are well established links between the Corporate Parenting Panel and Care to Change Council, and regular visits to front-line teams to meet workers. The Lead Member played a key role in ensuring that all looked after young people have direct access to social workers by the introduction of a policy to this effect, and in ensuring consistency on the policy of pocket money. Elected members express high

ambitions for children, but there are some areas where the panel could be more robust, for example in ensuring improvement in the quality of social work practice for all looked after children and in challenging the quality of educational provision and outcomes for those looked after children who are not benefiting from schools judged to be good or better.

The Local Safeguarding Children Board

The Local Safeguarding Children Board (LSCB) is inadequate.
The arrangements in place to evaluate the effectiveness of what is done by the authority and board partners to safeguard and promote the welfare of children are inadequate.

Summary of findings

The Local Safeguarding Children Board is inadequate because:

147. The Board has not been able to demonstrate sufficient awareness of whether children and families are being effectively safeguarded in Manchester, including the impact of high caseloads in social care and the overall quality of practice.

148. The Board has not evaluated sufficiently the effectiveness of partners' understanding and practice in relation to early help and its impact on contacts and referrals to social care.

149. Not all partners are appropriately engaged in the working of the Board, including leading key areas of the Board's business.

150. The Board structure is too complicated, and not all partners are engaged with its priorities or give sufficient time to the Board to ensure that all work is completed in a timely manner.

151. The Board has not been able to ensure that all recommendations from serious case reviews and management reviews have been fully completed within timescale.

152. The Board's annual report lacks sufficient analysis and does not include key areas of safeguarding, such as an evaluation of private fostering and a report on the work of the local authority designated officer (LADO).

153. Not all training is sufficiently evaluated in respect of learning and impact on practice.

What does the LSCB need to improve?

Priority and immediate action

Board operation and structure

154. Ensure that the Board has a full understanding of weaknesses in the delivery of services to children and families, particularly in social care, and takes effective steps to monitor and evaluate progress in ensuring that children are safe in Manchester.

155. Review and revise the Board structure to ensure that partners' full engagement is facilitated. Provide clear terms of reference for both the executive board and main board and for sub-groups of the Board in line with business priorities.

156. Ensure that the annual report provides an analysis of activity undertaken by the Board and their impact on improving the safety and outcomes for children. This should include an evaluation of private fostering arrangements and LADO activity.

Work programme

157. Review the Board's current business plan to ensure that it is correctly aligned, with the core priority safeguarding issues identified and agreed by all Board members.

158. Ensure that all outstanding recommendations from serious case and management reviews are actioned or reviewed for current relevance.

159. Review the impact of the early help offer and evaluate its effectiveness in terms of partner agency contributions and the impact on social care contacts and referrals.

Areas for improvement

Understanding the quality of practice

160. Fully embed the learning and improvement framework and ensure that all multi-agency and single agency audits are submitted on time to the Board and that Board members understand their responsibility for ensuring timely responses.

161. Ensure that the LSCB training programme is fully evaluated in order to inform future training needs, including lessons learned by staff and impact on practice.

162. Review and revise the Manchester safeguarding standard document so that it reflects changes in statutory guidance, and ensure that all Board members understand and agree to the standard.

163. Extend the current membership of the Board to include two lay members.

The LSCB's strengths

164. The LSCB Chair is a member of both the Health and Wellbeing Board and Children's Board and ensures that safeguarding issues and priorities are appropriately represented.

165. The previous LSCB Chair conducted a safeguarding review at the request of the local authority. The recommendations from the review, including the development of a MASH, have been accepted by the authority, which is helping to re-shape service delivery.

166. The LSCB produces a range of policies and procedures that are effectively monitored and evaluated for their effectiveness. These include safeguarding and gangs guidance, a child sexual exploitation strategy, a domestic abuse protocol and the 'one chance' strategy on forced marriage.

167. The child death overview panel operates effectively. Its annual report provides a comprehensive overview and analysis of child deaths and recommendations for action monitored by the board.

168. The Board has undertaken a number of thematic multi-agency audits arising from serious case reviews, including 'parents who misuse alcohol' and 'troubled teens'. Learning points from these have been the subject of training events, and have resulted in: the development of assessment tools to assist practitioners in identifying child sexual exploitation and neglect; implementation of the alcohol use disorders tool; and improving information sharing by the introduction of electronic flagging systems.

169. There are appropriate arrangements in place to undertake and publish serious case reviews, including appropriate liaison with the national panel of independent experts on serious case reviews.

170. There is a wide range of multi-agency safeguarding training available, which has been extended to community groups and organisations such as Madrasahs. There has also been a safeguarding conference involving 92 Madrasah representatives in October 2013.

171. The Board seeks to secure the views of children and young people, including using young people as part of case conference training, and a campaign in relation to online risk and 'sexting'. Plans are in place to recruit a young advisor to the Board.

Inspection judgement about the LSCB

172. The Board has not been able to demonstrate sufficient awareness of whether children and families are being effectively safeguarded in Manchester, including the impact of high caseloads in social care and the overall quality of practice.

173. The Board has not ensured that there are timely responses by agencies over submission of single agency audits and section 11 audits in order that it can satisfy itself that individual services are monitoring safeguarding practice

appropriately, and that the Board is appropriately aware of safeguarding issues and weaknesses.

174. The Board does not sufficiently understand the impact of the early help offer and whether all partners understand and promote good early help practice and how that can lead to better outcomes for children and families and reduced referrals to social care.

175. The Board has not been able to ensure that it conducts all its business in a timely manner and that it is able to deal with a high number of serious case and management reviews as well as other board business. This has led to delays in completing some key areas of work, such as a review of the functioning of the Board.

176. There are significant delays in fully completing recommendations from some serious case reviews published in 2013. The Board has not ensured that changes of personnel do not adversely affect the completion of these, and escalation of these issues to appropriate agencies has been ineffective in ensuring a solution.

177. The LSCB business plan is insufficiently focused on improvements in priority areas and too focused on business process and functionality of the Board. This means that the Board is not identifying through its business plan all the actions required to improve safeguarding in Manchester.

178. The Board structure is over- complicated, with too many sub-groups, of which too few are chaired by partner agencies. This has resulted in poor coordination between groups, duplication of work and, in some groups, inconsistent attendance, leading to delays in completing work on time.

179. The Board's document on members' responsibilities, 'the Manchester standard', is not up to date on 'Working together 2013', and the remits of the executive board and the main board are not defined well enough for all members to understand their separate but related functions.

180. Although the Board has access to some detailed analytical information, this is mostly from the local authority and the Board lacks a wider set of multi-agency data. This limits the Board's wider understanding of safeguarding issues.

181. Although some individual training courses are evaluated, the impact of training on practice has not been effectively evaluated over time, with a low agency response to an evaluation pilot. This means that the Board does not have an overview of the effectiveness of all of its training and whether outcomes for children and families are improving as a result.

182. The annual report of the Board is limited in its effectiveness and provides insufficient analysis of work undertaken. This means that it does not provide sufficient information to help determine priorities for the future.

What the inspection judgements mean

The local authority

An **outstanding** local authority leads highly effective services that contribute to significantly improved outcomes for children and young people who need help and protection and care. Their progress exceeds expectations and is sustained over time.

A **good** local authority leads effective services that help, protect and care for children and young people and those who are looked after and care leavers have their welfare safeguarded and promoted.

In a local authority that **requires improvement**, there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. Minimum requirements are in place. However, the authority is not yet delivering good protection, help and care for children, young people and families.

A local authority that is **inadequate** is providing services where there are widespread or serious failures that create or leave children being harmed or at risk of harm or result in children looked after or care leavers not having their welfare safeguarded and promoted.

The LSCB

An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

An LSCB **requires improvement** if it does not yet demonstrate the characteristics of good.

An LSCB that is **inadequate** does not demonstrate that it has effective arrangements in place and the required skills to discharge its statutory functions. It does not understand the experiences of children and young people locally and fails to identify where improvements can be made.

Information about the inspection and the review

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff worked with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of eight Her Majesty's Inspectors (HMI) from Ofsted.

The inspection team

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